STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 01 B. WING	11/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/16/11 Facility Number: 000069 Provider Number: 155148 AIM Number: 100288980 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, North Park Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (000) construction and was	K0000	The creation and submission of this plan of correection does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 103 and had a census of 91 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/21/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0020 SS=E	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 1 of 1 doors in vertical openings between floors was provided with a manufacturer's tag to prove at least a one hour fire resistance rating. This deficient practice could affect up to 24 residents, as well as staff and visitors in the F Hall.	K0020	K 0020Corrective action that will be accomplished for those residents found to have been affected by the deficient practice.The door to the basement on F Hall will be replaced with a one hour fire rating and with a fire rating tag attached.Residents identified having potential to be affected by the same deficient practice and corrective action taken:The residents on F hall have the potential to be affected.Measures	12/16/2011

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	Findings include: Based on observation on 11/16/11 at 12:00 p.m. during a tour of the facility with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor, the door to the basement in the F Hall was not provided with fire rating tag. This was confirmed by the Maintenance Supervisor and the Housekeeping/Laundry Supervisor at the time of observation. 3.1-19(b)		put into place or systemic changes made to ensure deficient practice does not recur:A one hour fire rated door with a fire rated tag has been ordered and will be installed by 12/16/11.Administrator and Maintenance Director have visually inspected the doors that require fire rating tags to ensure compliance monthly.Corrective actions will be monitored to ensure the deficient practice will not recur:Administrator/Maintenance Supervisor will visually inspect fire rating door tags on all doors that are required to have fire rating tags monthly.	
K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 91 of 91 residents in the event of an emergency addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the	K0048	K0048Corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*The Disaster Plan has been updated to include the use of the ABC type fire extinguishers and the K class fire extinguisher that is located in the kitchen. Residents identified having potential to be affected by the same deficient practice and corrective action taken: *All residents have the potential to be affected.Measures put into place or systemic changes made to ensure deficient practice does not	12/01/2011

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	fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's written fire safety plan in the Disaster Manual on 11/16/11 at 11:15 a.m. with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor present, the fire safety plan did not address the use of the ABC type fire extinguishers located throughout the building or the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Maintenance Supervisor and Housekeeping/Laundry Supervisor		recur:*The Dietary staff was inserviced on 11/30/11 by the administrator on the activation of the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher.*The Disaster Plan was updated to include the use of the ABC type fire extinguishers and the K class fire extinguisher that is located in the kitchen.*The Disaster Manual will be reviewed quarterly for any needed changes.Corrective actions will be monitored to ensure the deficient practice will not recur:*The Administrator/designee will review the Disaster Plan quarterly and make any recommendations to the CQI team.	

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	acknowledged the written fire safety plan did not include the use of the ABC type fire extinguishers or the kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher. 3.1-19(b)			
K0052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure documentation for the testing of all smoke detectors was correct. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's	K0052	K0052Corrective action that will be accomplished for those residents found to have been affected by the deficient practice:Administrator and licensed contractor have visually inventoried all smoke detectors and documented that inventory by location.Residents identified having potential to be affected by the same deficient practice and corrective action taken:All residents have the potential to be affected.Measures put into place or systemic changes made to ensure deficient practice does not recur:*Administrator and licensed contractor have done a visual inventory of all smoke detectors on 11/29/11 and 11/30/11. *A	12/16/2011

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	semiannual fire alarm system inspection reports in the Preventative Maintenance book on 11/16/11 at 10:30 a.m. with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor present, the two most recent semiannual fire alarm system inspection reports dated 04/22/11 and 10/25/11 were not accurate with the correct number of smoke detectors provided in the building. The cover page on both reports listed forty eight total smoke detectors (forty one Photoelectric smoke detectors and seven Duct Detectors), however, the itemized list of smoke detectors in each report listed forty two smoke detectors (without identifying the type of smoke detector) and thirteen Duct Detectors, for a total of fifty five smoke detectors. Finally, the most recent sensitivity test report dated 04/21/10 indicated only fifty total smoke detectors were tested. During an interview at the time of record review, the Maintenance Supervisor and the Housekeeping/Laundry Supervisor acknowledged the number of smoke detectors listed on the		complete system retest will be performed on 12/05/11 by licensed contractor.Corrective actions will be monitored to ensure the deficient practice will not recur:*All inspections and testing done by outside contractor will be monitored by Maintenance Supervisor/designee.*Inspection and testing documentation will be reviewed for accuracy by the administrator after each inspection by the outside contractor.*The administrator/designee will review audits in quarterly CQI meetings.	

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	cover pages, semiannual fire alarm system reports, and the most recent sensitivity test report were not consistent. 3-1.19(b)			